ENT-39 ELIMINATE MEDICARE PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
Outlays	265	320	340	360	380	1,670

Medicare beneficiaries are responsible for certain deductible and coinsurance amounts when they receive hospital inpatient services. For example, for calendar year 1995, the deductible amount for inpatient services is $716 per spell of illness. Currently, if the hospital makes a reasonable effort to collect these copayment amounts, Medicare will reimburse it for any remaining unpaid amounts. Eliminating these payments for enrollees' bad debts would reduce Medicare's payments to hospitals by $265 million in 1996 and almost $1.7 billion over the 1996-2000 period.

This option would give hospitals a financial incentive to expand their collection efforts, which would probably increase their recovery of enrollees' deductible and coinsurance amounts. Hospitals would not be able, however, to collect all the owed amounts. In particular, low-income enrollees who are not covered by Medicaid or other insurance may not be able to pay their hospital bills. As a result, this option would reduce revenues the most for those hospitals that are most likely to serve low-income Medicare patients. A drop in their Medicare payments might lead hospitals to cut back on the quality of their services or the amount of uncompensated care they provide, or to raise the rates they charge for other patients' care.

ENT-40 REVISE MEDICARE'S COST LIMITS FOR HOME HEALTH SERVICES AND SKILLED NURSING FACILITIES

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
Revise Limits for Home Health Services						
Outlays	10	303	463	524	575	1,875
Revise Limits for Skilled Nursing Facilities						
Outlays	86	218	292	326	357	1,278

Medicare's payments for home health care and the routine services of most skilled nursing facilities are based on the provider's reasonable costs, subject to specified limits. The limit on payments for each home health agency is calculated as the sum of the individual limits for the different types of visits (such as home health aide, speech therapy, and physical therapy) provided by the agency. The individual limits are set at 112 percent of the national average cost per visit incurred by free-standing home health agencies for each type of service. The limits are adjusted for differences in wage rates among market areas and for urban or rural location. Although the individual limits are used to compute each agency's total limit, they are not individually binding on a per-visit or per-service basis.

Medicare's limit on payments for the routine services of skilled nursing facilities is based on 112 percent of the average cost per day for routine services in free-standing facilities. For hospital-based facilities, the limit is increased by one-half of the difference between the limit for free-standing facilities and 112 percent of the average routine costs per day for hospital-based facilities. Limits are computed separately for urban and rural areas and are adjusted for differences in wage levels. Costs for ancillary services (such as physical therapy, occupational therapy, and speech therapy) and for capital-related expenses are not subject to the limit. Ancillary services now account for more than half of Medicare's payments to skilled nursing facilities.

Usually, the cost limits are computed each year so that they reflect the growth in average costs among providers. The Omnibus Budget Reconciliation Act of 1993 (OBRA-93), however, froze the limits for both home health services and skilled nursing facilities for two years. The limits are frozen until July 1, 1996, for home health services and October 1, 1995, for skilled nursing facilities.

Under this option, the method of computing the limits for home health services and skilled nursing facilities would be revised to extend the savings from the OBRA-93 freeze. Under current law, the increases in the limits during 1996 would reflect all of the growth that had occurred in average costs for each type of service since the previous increase in limits. By contrast, under the option, the next increase in the limits would reflect only one year of growth in average costs. Specifically, the limits would be modified by lowering them from 112 percent of the relevant average cost. The Health Care Financing Administration estimates that the revised proportions would be just over 100 percent for home health services and about 100 percent for skilled nursing facilities. This change would cut Medicare spending by $96 million in 1996 and nearly $3.2 billion over the 1996-2000 period compared with spending under current law.

For some facilities, revising the limits would probably have little effect because the facilities have already adjusted to the lower limits set by the freeze

--for example, by increasing their efficiency or generating higher revenues from other sources. Beginning in 1996, the limits would rise each year with the growth in average costs. Other facilities, however, may have had difficulty coping with the freeze and may therefore find it hard to adjust to the revised limits. For example, using the latest available data, which are primarily from 1990, the Health Care Financing Administration estimated that 36 percent of home health agencies had costs that exceeded their limit, and 61 percent of agencies had costs that would have exceeded a limit based on 100 percent of average costs. As a result, this option might adversely affect access to services or the quality of those services for some Medicare beneficiaries.

ENT-41 CONTINUE MEDICARE'S TRANSITION TO PROSPECTIVE RATES FOR FACILITY COSTS IN HOSPITALS' OUTPATIENT DEPARTMENTS

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	45	40	35	35	40	195

The Supplementary Medical Insurance (SMI) portion of Medicare pays for services provided in hospitals' outpatient departments. It makes separate payments to the facility and to physicians. The facility component includes reimbursement for the services of nonphysician personnel, drugs and biological products, other health services, rent, and utilities. Medicare previously reimbursed hospitals' outpatient departments on a reasonable-cost basis for most services. The Omnibus Budget Reconciliation Act of 1986, however, changed Medicare's payment method for the facility costs of most surgical procedures performed in hospitals' outpatient departments. The reimbursement that hospitals receive for these procedures is now based on the lesser of reasonable costs or charges, or a blend of that hospital-specific amount and the prospective rate received by freestanding ambulatory surgical centers (ASCs) in the area. In 1987, the Congress enacted a similar change for paying facility costs associated with outpatient radiology and diagnostic services. For outpatient surgery and radiology services, the hospital-specific share is 42 percent and the prospective-rate share is 58 percent. For other diagnostic services, the hospital-specific and prospective-rate shares are equally divided.

Outpatient payments are one of the fastest-growing components of SMI expenditures, accounting for a projected 25 percent in 1995. Between 1996 and 2000, SMI outlays for hospital outpatient services are expected to increase at an average annual rate of about 16 percent. A major factor in this increase is technological progress that allows hospitals and physicians to substitute outpatient surgery and technology for inpatient procedures. Furthermore, under the current reimbursement system, which is roughly half cost-based, hospitals' incentives to reduce the expenses of ambulatory surgery or outpatient radiology are limited because they would realize only about half the savings caused by any cost reduction. By contrast, ASCs have strong incentives to control costs because they are reimbursed prospectively, as are physicians who provide radiology services in their offices.

Under this option, the hospital-specific portion of the blended reimbursement rate for costs related to the use of facilities for outpatient surgery, radiology, and diagnostic services would be phased out in 1997, with a transitional blend for 1996 of 25 percent of costs and 75 percent of the prospective rate. Savings from current-law SMI spending would be $45 million in 1996 and $195 million over the 1996-2000 period.

In addition to cutting Medicare's costs, this option would result in the same payment system for hospital outpatient departments and ASCs. Thus, it would reduce the incentive and ability of hospitals to compete for patients through costly capital acquisitions. Hospitals would also have stronger incentives to control the costs of outpatient surgery, radiology, and diagnostic services because they could no longer automatically pass part of those costs through to Medicare. Some people are concerned, however, that access to care for rural Medicare beneficiaries might deteriorate; small and rural hospitals are more dependent on outpatient revenue than larger hospitals, and there are fewer alternatives to outpatient hospital services in rural areas. In addition, if patients at risk of complications are advised to receive treatment in hospitals' outpatient departments rather than ASCs because of the ready availability of advanced support systems in hospitals, paying higher rates to hospitals than to ASCs might be appropriate.

ENT-42 INCREASE AND INDEX MEDICARE'S DEDUCTIBLE FOR PHYSICIANS' SERVICES

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
Indexed to SMI Charges per Enrollee						
Outlays	640	1,210	1,620	2,120	2,680	8,270
Indexed to Consumer Price Index						
Outlays	640	1,070	1,190	1,340	1,460	5,700

One way to achieve appreciable federal savings in Medicare's Supplementary Medical Insurance (SMI) program is to increase the deductible--that is, the amount that enrollees must pay for services each year before the government shares responsibility. The deductible is now $100 a year and has been increased only three times since Medicare began in 1966, when it was set at $50. The deductible has fallen in relation to average annual per capita charges under the SMI program from 45 percent in 1967 to about 5 percent in 1994. In relation to the average annual Social Security benefit, the deductible has dropped from 5 percent in 1967 to 1 percent in 1994.

Increasing the SMI deductible to $150 on January 1, 1996, would save $640 million in fiscal year 1996. If the new deductible was indexed to the rate of growth in SMI charges per enrollee for 1997 and later years, savings would be $8.3 billion over the 1996-2000 period. By 2000, the deductible amount would be $227. If the deductible was tied to the consumer price index instead, savings would be $5.7 billion over the 1996-2000 period, and the deductible amount would be $169 in 2000.

An increase in the deductible amount would enhance the economic incentives for prudent consumption of medical care, while spreading the impact among most enrollees. No enrollee's out-of-pocket costs would rise by more than $50 in 1996.

The additional out-of-pocket costs under this option might, however, discourage some low-income enrollees who are not eligible for Medicaid from seeking needed care. In addition, costs to states would increase because their Medicaid programs pay deductible amounts for Medicare enrollees who also receive Medicaid benefits.

ENT-43 INCREASE THE COINSURANCE RATE FOR PHYSICIANS' SERVICES UNDER MEDICARE TO 25 PERCENT

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	1,370	2,230	2,510	2,890	3,360	12,360

Currently, the coinsurance rate on most services provided under Medicare's Supplementary Medical Insurance (SMI) program is 20 percent. One exception is outpatient psychiatric services, for which the coinsurance rate is 50 percent. The other exceptions are clinical laboratory services and home health care, which have no coinsurance requirements.

If, beginning on January 1, 1996, enrollees were required to pay coinsurance rates of 25 percent on all SMI services that are currently subject to a rate of 20 percent, savings to Medicare would be $1.4 billion in fiscal year 1996. Over the 1996-2000 period, savings would be $12.4 billion. Savings would be larger if coinsurance requirements were imposed on laboratory services and home health care as well.

This option would reduce Medicare's costs for two reasons. First, the higher coinsurance rate would reduce use of services by Medicare enrollees who do not have supplementary insurance coverage. Second, Medicare would be responsible for a smaller share of the costs of the services that enrollees use.

This option would, however, increase the risk of very large out-of-pocket costs for the 25 percent of enrollees who have no supplementary coverage and would probably increase medigap premiums for the 30 percent of enrollees who purchase supplementary insurance. Moreover, it would increase states' Medicaid costs for the 15 percent of enrollees who receive full or qualified Medicaid benefits.

ENT-44 COLLECT 20 PERCENT COINSURANCE ON CLINICAL LABORATORY SERVICES UNDER MEDICARE

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	510	800	890	1,030	1,160	4,390

Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to enrollees. Medicare's payment is set by a fee schedule and providers must accept that fee as full payment for the service. Beneficiaries pay coinsurance of 20 percent for most other services provided under Medicare's Supplementary Medical Insurance (SMI) program (as they did for clinical laboratory services before July 1984, when a fee schedule that reduced payment rates was put in place).

Reimposing the coinsurance requirement for laboratory services would yield appreciable savings to Medicare. If coinsurance of 20 percent of laboratory fees was imposed beginning January 1, 1996, federal savings would be $510 million in fiscal year 1996 and would total nearly $4.4 billion over the 1996-2000 period.

In addition to reducing Medicare's costs, this option would make cost-sharing requirements under the SMI program more uniform and therefore easier to understand. Moreover, enrollees might be somewhat less likely to have laboratory tests with little expected benefit if they paid part of the costs.

Cost sharing probably would not substantially affect the use of laboratory services by enrollees, however, because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing. Hence, the Congressional Budget Office assumes that a small part of the savings under this option would be the result of more prudent use of laboratory services, but most of the expected savings would reflect the transfer to enrollees of costs now paid by Medicare. Billing costs for some providers, such as independent laboratories, could be significantly higher because they would have to bill both Medicare and enrollees to collect their full fees. Currently, they have no need to bill enrollees directly for clinical laboratory services. In addition, states' Medicaid costs would increase for enrollees who also receive Medicaid benefits.

ENT-45 COLLECT 20 PERCENT COINSURANCE ON ALL HOME HEALTH AND SKILLED NURSING FACILITY SERVICES UNDER MEDICARE

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays for Home Health	2,381	3,898	4,513	4,985	5,463	21,240
Outlays for Nursing	244	461	567	652	752	2,676
Total	2,625	4,359	5,080	5,637	6,215	23,916

Copayments are not currently required from enrollees for home health services under Medicare. Copayments for skilled nursing facility (SNF) services are required for each day after the first 20 days of care; the coinsurance amount per day is equal to one-eighth of the deductible amount for hospital care and is unrelated to SNF costs.

If enrollees were required to pay coinsurance amounts equal to 20 percent of the projected average cost for each home health visit and each SNF day, the net savings to Medicare would be $2.6 billion in 1996. Over the five-year projection period, savings would be $23.9 billion.

This option, together with the laboratory coinsurance requirement discussed in ENT-44, would establish a uniform coinsurance rate of 20 percent on almost all Medicare services. This uniform rate would make Medicare's copayment requirements easier for providers and patients to understand. Further, because coinsurance amounts would be based on the cost of services, they would encourage enrollees who lack supplementary insurance coverage to consider relative costs appropriately when choosing among alternative treatments. As a result, the use of home health and SNF services might fall. Only hospital inpatient services would require no copayments (for most stays) except for the deductible amount. But under the prospective payment system, patients are unlikely to remain hospitalized longer than necessary because hospitals have strong incentives to discharge them quickly.

Many enrollees have supplementary insurance that eliminates their Medicare copayment costs, and this option would not affect their use of services. It would, however, increase medigap premiums for about 30 percent of enrollees who purchase that kind of supplementary insurance, and it would increase state's Medicaid costs for the 15 percent of enrollees who also receive Medicaid benefits. Moreover, this option would increase the risk of very large out-of-pocket costs for the 25 percent of enrollees who lack any supplementary coverage.

ENT-46 PROHIBIT FIRST-DOLLAR COVERAGE UNDER MEDIGAP POLICIES

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
Outlays	4,220	6,630	7,280	7,990	8,800	34,920

About 30 percent of Medicare enrollees purchase supplementary private insurance (medigap coverage) that pays all or most of Medicare's copayment requirements for them. Medigap policyholders use about 24 percent more services than they would if they did not have first-dollar coverage. But most of the costs of these additional services are paid by the federal government through Medicare, not by medigap insurers.

Federal costs for Medicare could thus be reduced if medigap plans were prohibited from offering first-dollar coverage for Medicare's copayment requirements. If, for example, medigap plans were prohibited from paying any portion of the first $1,500 of an enrollee's copayment liabilities for the year, use of medical services by medigap policyholders would fall, and federal savings for 1996 would be $4.2 billion. Assuming that the medigap limit would be linked to growth in the average value of Medicare's copayment requirements for later years, savings over the 1996-2000 period would total $34.9 billion. This estimate includes savings from medigap plans provided by employers as a benefit for retirees.

Only enrollees who have medigap policies would be directly affected by this option, and most of them would be financially better off under it. Because their medigap premiums would decrease more than their out-of-pocket liabilities would increase, most medigap enrollees would have lower expenses during the year under this approach. Indirectly, all enrollees might be better off because Medicare's premiums would be lower than under current law.

Medigap holders would have to assume a higher level of financial risk for Medicare-covered services than they do now, however. Because they might feel more uncertain about their expenses, some policyholders might object to eliminating their option to purchase first-dollar coverage even if in most years they would be financially better off. Moreover, about a quarter of people with medigap policies would actually incur higher expenses in any given year, and those with expensive chronic conditions might be worse off year after year. Finally, the decrease in use of services by medigap holders that would generate federal savings under this option might not be limited to unnecessary care, so the health of some of them might be adversely affected.

ENT-47 INCREASE THE PREMIUM FOR PHYSICIANS' SERVICES UNDER MEDICARE TO 30 PERCENT OF PROGRAM COSTS

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	2,660	3,900	4,390	6,330	9,020	26,300

Benefits under Medicare's Supplementary Medical Insurance (SMI) program are partially funded by monthly premiums paid by enrollees, and the remainder are paid from general revenues. Although the SMI premium was initially intended to cover 50 percent of the cost of benefits, between 1975 and 1983 premium receipts covered a declining share of SMI costs--falling from 50 percent to less than 25 percent. This drop occurred because premium increases were limited by the cost-of-living adjustment (COLA) for Social Security benefits (which is based on the consumer price index), but the per capita cost of the SMI program increased faster. Since 1984, premiums have been set to cover about 25 percent of average benefits for an aged enrollee, although under current law the COLA will again determine the premium adjustment beginning with the 1999 increase.

If the premium was set to cover 30 percent of benefits for 1996 and all years thereafter, $2.7 billion would be saved in 1996 and $26.3 billion over the 1996-2000 period. The premium for 1996 would be $54 a month instead of $45. These estimates assume a continuation of the current hold-harmless provision, which ensures that no enrollee's monthly Social Security check will fall as a result of the Social Security cost-of-living adjustment (which is based on the whole benefit) being smaller than the SMI premium increase.

Most SMI enrollees would pay a little more under this option, in contrast to proposals--such as increasing copayments--that could substantially increase the out-of-pocket costs of those who become seriously ill. This option need not affect enrollees with income below 120 percent of the federal poverty threshold because all of them are eligible to have Medicaid pay their Medicare premiums, although some who are eligible for Medicaid do not apply for benefits.

Low-income enrollees who are not eligible for Medicaid, however, could find the increased premium burdensome. A few might drop Supplementary Medical Insurance coverage and either do without care or turn to sources of free or reduced-cost care, which could increase demands on local governments. In addition, states' expenditures would rise because states would pay part of the higher premium costs for those Medicare enrollees who also receive Medicaid benefits.

ENT-48 RELATE THE PREMIUM FOR PHYSICIANS' SERVICES UNDER MEDICARE TO ENROLLEES' INCOME

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
50 Percent Ceiling						
25 Percent Basic Premium	0	0	0	1,329	3,387	4,716
Income-Related Premium	960	1,554	1,851	2,205	2,627	9,197
Total	960	1,554	1,851	3,534	6,014	13,913
100 Percent Ceiling						
25 Percent Basic Premium	0	0	0	1,329	3,387	4,716
Income-Related Premium	633	1,185	1,429	1,724	2,080	7,051
Total	633	1,185	1,429	3,053	5,467	11,767

Instead of increasing the basic premium to 30 percent of costs for all enrollees under the Supplementary Medical Insurance (SMI) program, this option would collect relatively more from higher-income people. Under one version, individuals with modified adjusted gross income of less than $50,000 and couples with income lower than $65,000 would pay only the basic premium, set at about 25 percent of SMI costs per enrollee. Premiums would rise progressively for higher-income enrollees, however. The maximum total premium would be set to cover 50 percent of costs for individuals with income exceeding $60,000 and for couples with income exceeding $80,000.

Under a second version, nearly the same five-year savings could be achieved by setting the maximum total premium to cover 100 percent of costs for individuals with income exceeding $125,000 and for couples with income over $150,000. Under this version, income-related premiums would begin at $100,000 for individuals and $125,000 for couples. In both cases, the income-related premiums would have to be collected through the income tax system so that rates could be aligned with income. Current premiums are deducted automatically from Social Security checks for most enrollees.

If the 50 percent option was carried out for calendar year 1996, savings would total $960 million in fiscal year 1996 and $13.9 billion over the 1996-2000 period. Under the 100 percent option, savings would total $11.8 billion over the five-year period. These estimates assume that the current hold-harmless provisions would continue only for people subject to the basic 25 percent premium. (The hold-harmless provisions ensure that no enrollee's Social Security check will decrease because an increase in the SMI premium exceeds the cost-of-living adjustment.)

Most SMI enrollees would be unaffected by the portion of the premium that is related to income. Under the 50 percent option, roughly 92 percent of enrollees would face the basic 25 percent premium, about 6 percent would pay the maximum premium, and 2 percent would pay a premium somewhere in between. Under the 100 percent option, only about 2 percent of enrollees would be subject to the income-related premium.

Enrollees subject to the income-related premium would pay substantially more, however. Under the 50 percent option, the maximum monthly premium for 1996 would be $89.10 instead of the $44.60 pre-

mium projected under current law. Under the 100 percent option, the maximum monthly premium would be $178.20. That change might lead some enrollees to drop out, although it is estimated that fewer than 0.5 percent would do so. Those with retirement health plans that do not require Medicare enrollment (largely retired government employees) would be most likely to drop out. Some healthy enrollees who have no other source of health insurance might do so as well, if they were not averse to the risk that they might incur large health care costs.

ENT-49 MODIFY THE PROCESS FOR UPDATING PHYSICIANS' FEES UNDER THE MEDICARE FEE SCHEDULE

Savings from Current-Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Outlays	410	820	1,350	1,880	2,150	6,610

Constraining growth in the volume of physicians' services is an important component of Medicare's cost containment objectives. The volume performance standard (VPS) has been Medicare's principal tool for moderating growth in spending for physicians' services under the Medicare fee schedule (MFS). Unless the Congress overrides the default process, fees under the MFS are updated by the increase in an index of physicians' costs (the Medicare economic index, or MEI), modified by a penalty or bonus determined by how much growth in the volume of services in a previous period exceeded or fell below targets set by the VPS.

In its 1994 annual report, the Physician Payment Review Commission recommended five modifications to the VPS: 1) limit each update to no more than 5 percentage points above the MEI, matching the limit on reductions that is currently in place; 2) base each update on the cumulative disparity between actual growth and VPS targets from some base year (say 1994), instead of on the disparity only for the previous year; 3) incorporate VPS penalty adjustments to the update into the targets in the same way that the adjustments are set by law (that is, with no offsetting increase in volume assumed); 4) base target allowances for volume increases on historical growth in real gross domestic product per capita (plus, say, 1 percentage point to account for new technology) instead of on historical growth in volume per enrollee minus the current "performance standard factor"; and 5) reestablish resource-based relative values for payment rates and maintain them by using a single target and update for all services, eliminating the separate targets and updates now existing for primary care, surgical, and other nonsurgical services. If the effects of different updates by service category in recent years on MFS rates were eliminated for 1996 in a budget-neutral way, and if the five recommendations described here were put in place and effective for the 1996 update, Medicare's spending under the MFS would be reduced by $410 million that year. Savings through 2000 would total $6.6 billion.

These modifications would improve the VPS as a tool for cost control. The first two would ensure that any spending above the target could be fully recovered in later years through smaller increases in payment rates. The third modification would eliminate an unintended effect of the current system of calculating the VPS, under which spending targets are increased for years in which a VPS penalty is imposed.

The fourth modification would link spending on services to growth in the nation's resources from which payment must come, and would enhance physicians' incentives to constrain increases in volume. Under the current system, a reduction of the growth in volume leads to an immediate increase in fees, but only at the expense of lower targets in the future; thus, it offers only a temporary reward for a permanent reduction in volume.

The fifth modification would restore the integrity of the resource-based relative value scale that was the foundation for the Medicare fee schedule, which was put in place to rationalize the basis for Medicare's physician payment rates. One of the objectives of the MFS was to improve payment rates for primary care in relation to specialists' services, in part because health care was expected to be less costly in a system less dominated by specialties. That objective has been undermined in recent years by the default update process, which has produced higher payment rate increases for specialists' services than for primary care services.

These changes would, however, reduce MFS rates significantly below what they would otherwise be. In 1996, for example, MFS rates would be 2.8 percent lower, and by 2000 they would be about 9 percent lower. Unless rates paid by other insurers dropped by similar amounts, Medicare's rates would further erode in relation to those of other payers, perhaps threatening access to mainstream health care for Medicare enrollees.

ENT-50 REDUCE FEDERAL EMPLOYEE RETIREMENT COSTS

Savings from Current-Law Spending	Annual Savings (Millions of dollars) 1996	1997	1998	1999	2000	Cumulative Five-Year Savings
Defer COLAs for Retirees						
Military Retirement	0	410	880	1,810	2,380	5,480
Civilian Retirement	60	200	290	360	410	1,310
Limit Some COLAs Below Inflation						
Military Retirement	0	260	550	1,120	1,490	3,420
Civilian Retirement	90	330	530	750	970	2,670
Reduce COLAs to Middle- and High-Income Retirees						
Military Retirement	0	240	530	1,090	1,460	3,320
Civilian Retirement	170	620	1,000	1,390	1,800	4,980
Modify the Salary Used to Set Pensions						
Military Retirement	20	40	70	90	120	340
Civilian Retirement	10	40	70	110	160	390
Restrict Agency Match on Thrift Plan Contribution to 50 Percent						
Civilian Retirement[a]	320	460	490	520	550	2,340
Raise Employee Contributions						
Civilian Retirement[b]	740	1,780	2,080	2,130	2,230	8,960

a. Savings from the 1995 funding level adjusted for inflation.

b. Addition to current-law revenues.

About 4.5 million government employees are covered by federal civilian and military retirement programs. The Federal Employees' Retirement System (FERS) covers civilian employees hired since January 1984. FERS supplements Social Security, in which workers who are covered under FERS also participate. When FERS was created, workers hired before 1984 had the option to join. Most civilian employees not in FERS are covered by the Civil Service Retirement System (CSRS). Employees who are covered under CSRS do not participate in Social Security. Uniformed military personnel are covered by the Military Retirement System (MRS), which was revised for personnel entering the service after July 31, 1986, and by Social Security. Federal retirement payments totaled $63 billion in 1994.

There are three basic approaches to reducing the costs of federal retirement--namely, cutting benefits earned by employees, increasing employee contributions, or cutting benefits paid to retirees. The options described here differ according to who would be affected. The increase in contributions, for example, would affect workers who must contribute more of